Comprehensive Medication Review Worksheet

Patient Name: _____ Age: _____ Sex: _____

Reason for Visit: _____ PCP: _____

Chronic Problems	Medications (Dose, Frequency)	Relevant Labs, VS, Notes
1.	1.	
	2.	
	3.	
2.	1.	
	2.	
	3.	
3.	1.	
	2.	
	3.	
4.	1.	
	2.	
	3.	
5.	1.	
	2.	
	3.	
6.	1.	
	2.	
	3.	
7.	1.	
	2.	
	3.	
8.	1.	
	2.	
	3.	
9.	1.	
	2.	
	3.	
10.	1.	
	2.	
	3.	

☐ Does every medication have a valid indication?

☐ Is every medication appropriate for the condition being treated? (Remember to assess appropriateness of dose, frequency, etc.)

☐ Are there any untreated conditions?

Est CrCl

ABW ____kg
IBW ____kg
AjBW ____kg
SCr ____mg/dL
CrCl ____mL/min

Cognitive Testing

Hospitalizations & ED Visits (past 12 months)

Date	Discharge DX
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Activities of Daily Living

- ☐ Dressing
- ☐ Bathing
- ☐ Transferring
- ☐ Toileting
- ☐ Feeding
- ☐ Continence
- ☐ Food Preparation
- ☐ Finances
- ☐ Transportation
- ☐ Telephone
- ☐ Medication Management
- ☐ Laundry/ Housekeeping

Additional Notes